Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

JOSEPH W. NAWROCKI, MD
P O BOX 741865
DALLAS, TX 75374

Respondent Name
ZURICH AMERICAN INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-12-2968-01

MFDR Date Received
MAY 23, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER IS REQUIRED TO PAY DESIGNATED DOCTOR EXAMS…THE CURRENT RULES ALLOW REIMBURSMENT…AN ORIGINAL BILL AND A RECONSIDERATION WERE SUBMITTED, THE CURRENT RULES ALLOW REIMBURSEMENT."

Amount in Dispute: $590.54

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 16, 2012	99456-RE-W8, 95831	$590.54	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out guidelines for medical bill submissions by a health care provider.
3. 28 Texas Administrative Code §133.10 sets out guidelines for health care provider required billing forms/formats.
4. Neither the requestor nor the respondent submitted copies of any explanations of benefits.

Issues

1. What are the billing requirements for box 1a of a CMS-1500 form?
2. Did the requestor complete the disputed medical bill in accordance with 28 Texas Administrative Code §133.10 (f)(1)(A)?

3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.10 (f) states, "All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form.

   28 Texas Administrative Code §133.10 (f)(1)(A) states, "(1) The following data content or data elements are required for a complete professional or noninstitutional medical bill related to Texas workers' compensation health care: (A) patient's Social Security Number (CMS-1500/field 1a) is required.
2. A review of the requestor's documentation finds two letters from the respondent in response to requestor' s initial and reconsideration submissions of the disputed bill. The letter's are dated, February 15, 2012 and March 6, 2012 which state, "This bill does not belong to a WC, NS, AN claim. To further consider this billing for payment, please send: A copy of the bill along with the requested information, or documentation. Please also be certain that the injured employee's social security number and date of injury are noted on the billing. Upon receipt of this information, your billing will be placed in line for processing." Further review of the requestor's documentation finds a copy of the initial bill and reconsideration bill. The requestor completed box 1a, however, only included the last four digits of the injured employee's social security.
3. In accordance with 28 Texas Administrative Code §133.10 (f)(1)(A) the Division concludes that the requestor is not entitled to reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		March 1, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.